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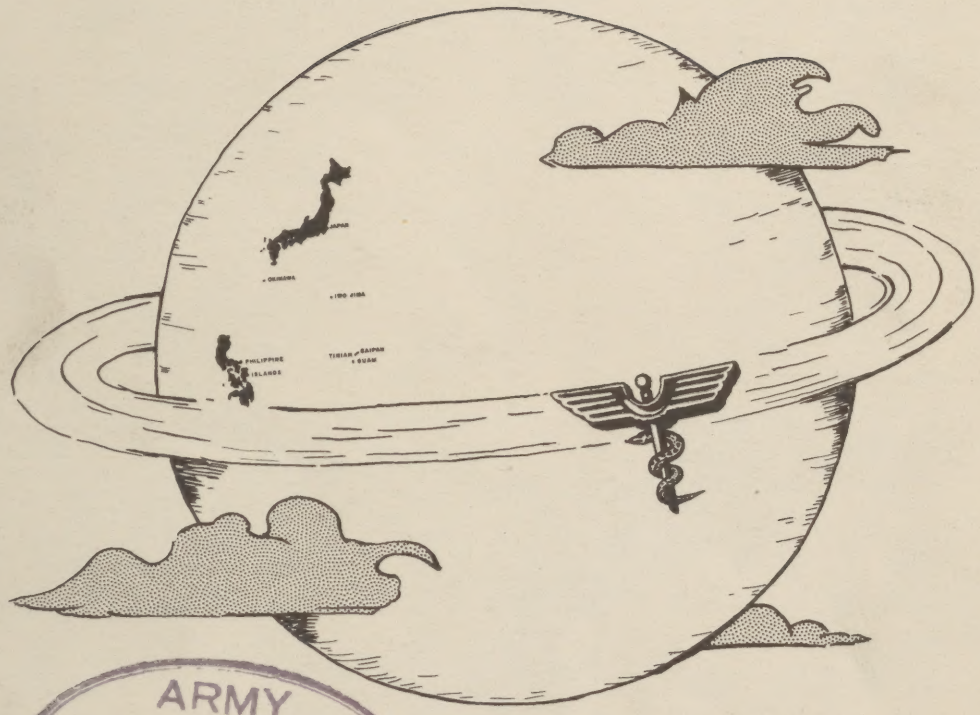
MED. SEC. GHQ. FEC.

VOL V NO 4
1 APR 1950



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SURGEON'S CIRCULAR LETTER

RESTRICTED

NEW UNIFORMS FOR ARMY NURSES, WMSC & OTHER SERVICE WOMEN

A complete changeover of uniforms for Army Service women as shown above was displayed at a premiere showing held at Fort Jay, Governors Island, N.Y. on February 23, 1950. Changes were made in color, designs, tie discarded, and a definite feminine styling added. Although officially adopted, the new uniforms will not become regulation wear until January, 1951. From left to right: the service uniform and hat in taupe, with cap, brown leather handbag matching the shoes; the new overcoat; the summer uniform of white palm beach cloth with hat, handbag and shoes to match; the summer dress uniform in beige taupe cotton chambray broadcloth; the field jacket and skirt in taupe with matching cap; the blouse and skirt. Buttons and insignia are antique gold on all uniforms.

GENERAL HEADQUARTERS
FAR EAST COMMAND
MEDICAL SECTION

SURGEON'S CIRCULAR LETTER APO 500

NO. . . . . 4 1 April 1950

PART I

ADMINISTRATIVE

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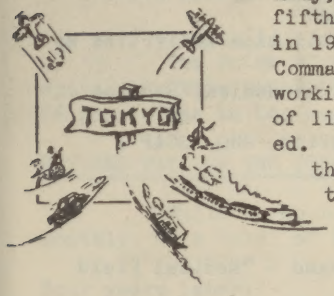
I. Organization of the Medical Section

Arrivals in the Medical Section, GHQ, FEC: Lt. Colonel Alice M. Gritsavage, ANC, arrived from the ZI for assignment in the Consultants Division.

Captain Richard M. Stacey, MSC, arrived from the ZI for assignment in the Supply and Fiscal Division.

II. FEC Conference of Major Command Surgeons Ends



A conference of the major command surgeons and senior medical officers of the Army, Navy and Air Forces was held from 20 March through 25 March 1950. This was the fifth conference of surgeons held in Tokyo since the formation of AFPAC Headquarters in 1945. The meeting was held to consider Medical Department problems of the Far East Command and the means whereby Medical Departments of the Army, Navy and Air Forces, by working closely together could find the solutions with greater efficacy. The problems of limited doctor personnel and insufficient numbers of medical specialists were stressed. At the same time, it was brought to the attention of the officers present that there was no reduction of the responsibilities of the medical service. On the contrary, it was emphasized that during 1950 our service would be faced with problems of greater complexity in view of the shortage of Medical Corps officers and the ever-increasing commitments for medical care. Such problems still exist despite the fact that great progress has been accomplished in the overall medical service.

The outstanding feature of the conference was the spirit of unity and cooperation which prevails among the members of the three medical services within the Far East Command.

SPEAKERS

First Day, Monday, 20 March 1950

Major General Doyle O. Hickey, Deputy Chief of Staff, Far East Command

Vice-Admiral C. T. Joy, Commander, U. S. Naval Forces, Far East
Major General J. M. Weikert, Vice-Commander, Far East Air Forces
Brigadier General E. K. Wright, Asst. Chief of Staff, G-3, Far East Command
Major General G. L. Eberle, Asst. Chief of Staff, G-4, Far East Command
Major General C. A. Willoughby, Asst. Chief of Staff, G-2, Far East Command
Address by Major General Edgar Erskine Hume, Chief Surgeon, Far East Command
Colonel Robert J. Platt, MC, Surgeon, Far East Air Forces - "Medical Service and Medical Problems of the Far East Air Forces"
Captain J. B. Butler, MC, (USN), Senior Medical Officer, U. S. Naval Forces, Far East
Colonel Harold G. Ott, DC, Dental Surgeon, Far East Command - "Dental Service in the Far East Command"
Lt. Colonel W. S. Smith, MC, Surgeon, Headquarters and Service Group, Far East Command - "The Medical Service, Headquarters and Service Group"

Second Day, Tuesday, 21 March 1950

Colonel Chauncey E. Dovell, MC, Surgeon, Eighth Army - "Eighth Army Medical Service"
Lt. Colonel E. W. Partin, MSC, Chief, Supply and Fiscal Division, Medical Section, Far East Command - "Supply and Fiscal"
Major G. C. Irving, MSC, Asst. Chief, Supply and Fiscal Division, Medical Section, Far East Command - "Budget"
Colonel Theodore C. Bedwell, MC, Surgeon, 5th Air Force - "Medical Service and Medical Problems, Fifth Air Force"
Lt. (jg) Lincoln D. Nelson, MC, (USN), U. S. Naval Forces, Philippines - "U. S. Naval Medical Facilities, Philippines"
Lt. Colonel Charles Raulerson, MSC, Chief, Personnel Division, Medical Section, Far East Command - "Medical Department Personnel"
Colonel Leonard N. Swanson, MC, Surgeon, Marianas-Bonins Command - "Marianas-Bonins Medical Service"
Lt. Colonel Harlan H. Taylor, MC, Surgical Consultant, Far East Command - "Surgical Service, FEC"

Third Day, Wednesday, 22 March 1950

Colonel James L. Snyder, MC, Surgeon, Ryukyus Command - "Medical Service on Okinawa"
Major Harvey E. Archer, MSC, Asst. Chief, Plans and Operations Division, Medical Section, Far East Command - "Deaths and Pay Patients"
Captain Vincent I. Hack, MSC, Chief, Publications and Editorial Branch, P&O Division, Medical Section, Far East Command - "Certain Medical Department Reports and Publications"
Captain Lawrence E. Bach, MC, (USN), Senior Medical Officer, U. S. Naval Medical Center, Guam - "Navy Medical Situation in the Marianas"

Fourth Day, Thursday, 23 March 1950

Lt. Colonel Arthur P. Long, MC, Preventive Medicine Consultant, Medical Section, Far East Command - "Status of Health of the Far East Command"
Colonel Howard W. K. Zellhoefer, MC, Surgeon, 20th Air Force - "Getting Going on Okinawa Gunta"
Major Mildred I. Clark, ANC, Chief Nurse, Far East Command - "Nursing Service"
Lt. Colonel L. C. Fairbank, Jr., Engineer Section, GHQ, FEC - "Repairs and Utilities Activities as They Pertain to Hospitals"
Lt. Colonel Furman L. Foster, MC, Surgeon, Far East Air Materiel Command - "The Medical Service and Medical Problems of the Far East Air Materiel Command"
Brigadier General Crawford F. Sams, MC, Chief, Public Health and Welfare Section, GHQ, SCAP - "Public Health and Welfare Problems in Japan"

Fifth Day, Friday, 24 March 1950

Lt. Colonel Robert L. Hullinghorst, MC, Laboratory Consultant, Far East Command - "Medical Field Work"
Colonel Irby L. Pollard, VC, Veterinary Consultant, Far East Command - "Veterinary Service of the Far East Command"
Captain R. D. Wilson, MC, Surgeon, 1503d Air Transport Wing, PACD, MATS, Haneda Air Base - "The Role of Air Evacuation in Military Medicine"

III. An Army Career

If a doctor selects the Army as a career, what can he expect in the way of pay, allowances and other benefits? With what gross income in civilian practice are those comparable? Let us make this comparison over a period of 30 years. We will assume that the doctor is entering the Army without prior military service. (Figures compiled in the Surgeon General's Office)

AS A FIRST LIEUTENANT, MEDICAL CORPS:

Pay for the first 2 years	$ 4,192.00
Allowances (married)	1,494.00
After 20 years service he can retire with $523.69 per month for life. For the civilian practitioner to purchase an annuity which will pay him $410 per month at the age of 65 years will cost $1,828 per year for 30 years (if he starts at the age of 25 years) and he will not collect any benefits until 65 years of age	1,828.00
If the Army officer dies his beneficiary gets 1/2 year's pay. To obtain insurance to get the same result will cost the doctor in civil life per year.	25.00
Living on an Army Post he gets free dental care; hospital bills are $1.35 per day. He will save on gasoline, movies, laundry, barber bills and Post Exchange purchases, varying amounts, but well in excess of $500 per year.	500.00
Total Pay and Benefits.	8,039.00
Income Tax (married - 1 dependent)	425.00
	$ 7,614.00

CIVILIAN DOCTOR:

Let us assume he will have a practice from the start wherein he will collect $12,000 a year (less than 16% of all doctors had that large a gross income in 1949, an excellent peace-time year)	$12,000.00	
Office expenses are 33-1/3 to 36% -- take the lower figure	4,000.00	
	8,000.00	
Income Tax (married - 1 dependent)	1,388.00	
Take home pay	$ 6,612.00	

Thus, it appears a 1st Lieutenant's remuneration and benefits exceed in value those of a physician collecting $12,000 and WE HAVEN'T INCLUDED:

One month's vacation a year on full pay;
Full pay while taking a postgraduate course -- Army paying the tuition;
Full pay while sick;
Retirement at 3/4 pay for life if totally disabled for Army duty.

The value of this benefit cannot be computed, as no insurance company writes a policy that approaches this benefit. It assures the Medical Corps officer that he won't be on relief rolls as were 74 physicians in Los Angeles County in 1948.

RETIRED PAY FOR THE TEN-YEAR PERIOD (Age 55 - 65 years):

While he would wait for an annuity policy to commence payments, the Army will pay him $523.69 monthly, or a total of $62,842.80

Four years later: -

Captain, Medical Corps, 4-years service pay	$ 5,133.00
Allowances	1,584.00
Annuity equivalent (see above)	1,828.00
Insurance to cover death gratuity	25.00
Savings on cost of living	500.00
	9,070.00
Income Tax (married - 1 dependent)	588.00
	$ 8,482.00

Compare this with civilian physicians with a gross income of $14,000 (less than 11% of all doctors grossed that much in 1949)	$14,000.00	
Expenses, one-third	4,666.00	
Net	9,334.00	
Income Tax (married - 1 dependent)	1,745.00	
	$ 7,589.00	

After a total of 12 years:

Major, Medical Corps - pay		$ 6,330.00
Allowances		1,764.00
Annuity equivalent		1,828.00
Insurance to cover death gratuity		25.00
Savings on cost of living		500.00
		10,447.00
Income Tax (married - 1 dependent)		978.00
		$ 9,469.00

Compare this with the gross income of a civilian doctor of	$16,000.00	
Expenses, one-third	5,333.00	
	10,667.00	
Income Tax (married - 1 dependent)	2,144.00	
	$ 8,523.00	

After 18 years:

Lieutenant Colonel, Medical Corps - pay		$ 7,527.00
Allowances		1,944.00
Annuity equivalent		1,828.00
Savings on cost of living		500.00
Death gratuity now $2,300 insurance cost		30.00
		$11,829.00
Income Tax (married - 1 dependent)		1,263.00
		$10,566.00

Compare this with the gross income of a civilian doctor of	$18,000.00	
Expenses, 33-1/3%	6,000.00	
	12,000.00	
Income Tax (married - 1 dependent)	2,571.00	
	$ 9,429.00	

After 30 years service:

The Medical Corps officer has spent 25 years getting prepared for work, 30 years in practice, and now anticipates several years of retirement. He can retire on $523.69 a month for life. This is the equivalent of 3% interest per annum on $209,475.96.

He has his retirement.
He has bonds, savings, investments and insurance saved from his pay.

These two added amount to a sum, that if the civilian physician wishes to equal, he will have had to save an average of over $4,000 a year for 30 years. Look at his take-home pay after taxes, and how could he?

He has a month's leave on full pay yearly.
He had had postgraduate courses on full pay.
He had had excellent opportunities for himself and his family to travel.
He had had access to a wealth of clinical material.

IV. National Foundation for Infantile Paralysis Professional Publications

Information has been received from the National Foundation for Infantile Paralysis that requests from individuals and installations for their professional publications on poliomyelitis have become so numerous that they are unable to fill all requests. Therefore, the Foundation has suggested that in order to insure the most advantageous distribution of such professional publications, an office be designated in this overseas command through which all requests could be screened to assure that the material requested will be utilized for the benefit of the greatest number of people. To assist the Foundation in this program, it is requested that all military requests from this command be sent to the Medical Section, General Headquarters, Far East Command, APO 500, rather than direct to the National Foundation for Infantile Paralysis.

The following is a list of medical reprints distributed by the Foundation of interest to Medical Department officers.

MR-25: Some Diagnostic Aids in Acute Anterior Poliomyelitis - Postgraduate Medicine - Aug 1947
MR-26: The Psychological Sequelae of Poliomyelitis in Children - The Nervous Child - Dr. Morton A. Seidenfeld
MR-34: Exhibit on Treatment of Infantile Paralysis
MR-35: Exhibit on Bulbar Poliomyelitis
MR-38: Report on Polio - The Merck Report, January, 1949 - Dr. H. E. Van Riper
MR-40: Chemotherapy of Poliomyelitis - American Professional Pharmacist - April, 1949 Dr. H. E. Van Riper
MR-41: Functional Testing & Training - Physical Therapy Aspects - Physical Therapy Review, R. L. Bennett, M.D., and Hazel Stephens, B.S., M.S.
MR-44: Symposium on Poliomyelitis - American Journal of Medicine - 1949 (Reference copies only - supply limited)
MR-45: Treatment of Infantile Paralysis (Scientific Exhibit) - Postgraduate Medicine, 1949
MR-46: The Diagnosis and Treatment of Bulbar Poliomyelitis - Southern Medical Journal, 1949 - Dr. Stimson
MR-50: Epidemiology of Poliomyelitis in the Light of Modern Research - American Journal of Medicine - Dr. Howard A. Howe
MR-51: Exhibit on Laboratory Aids to Clinical Diagnosis

V. Rigors of Arctic Tested by Army Medical Unit

Camp Shilo, Manitoba, was the scene of the Army Medical Department's second winter field exercises on Canadian soil. The training program with both American and Canadian personnel participating, started 1 February and continued for one month. This program was similar to an exercise held in the area in 1949 for the purpose of testing the performance of medical equipment in sub-zero temperatures.

VI. Researchers Study Dental Hygiene

A decrease in the prevalence of tooth decay in the Army may result from experiments being conducted in the Dental Division, Army Medical Department Research and Graduate School, Washington, D.C.

Foremost among the Division's research projects is the study of the factors responsible for and contributing to the development of dental caries in adults and the prevention and control of caries.

VII. Medical Education

Professional education for Medical Department officers and warrant officers in civilian educational institutions will be continued during fiscal year 1951. Courses offered and universities in which they will be given are listed in AR 350-230-60. Within budget allowances and the number of spaces available, the maximum number of qualified officers will be enrolled in these courses.

VIII. Hospital Funds

Pending the revision of GHQ Circular 2 on Hospital Funds, 6 January 1949, Form DA AGO 8-201 will no longer be required.

IX. SR 140-180-15, Organized Reserve Corps

This command has a number of civilians who hold Reserve commissions in the Army. Some of these individuals are called or ordered to active duty from time to time, or are engaged in Reserve duty training.

This Special Regulation provides the procedure for the administration of that portion of Public Law 108, 81st Congress, as it applies to members of the Reserve who suffer injury or death in line of duty while on active duty or in Reserve duty training. The Act of 3 April 1939 (53 Stat 557) as amended by Public Law 108, 81st Congress, entitles this category of Reserves certain benefits.

Reservists who are ordered or called to active duty in excess of 30 days are, after entry on active duty, entitled to benefits, if disability or death is the result of disease or injury contracted or incurred in line of duty; however, those who are on active duty for 30 days or less are entitled to benefits only if the disability or death is a result of injury incurred in line of duty after entry on active duty. Reservists ordered to perform Reserve duty training are entitled to benefits only if the disability or death is a result of an injury incurred in line of duty while employed in such Reserve duty training.

The regulation covers restrictions and limitations of benefits, and investigation to determine the line of duty for disease, injuries or death. It further provides that hospital commanders will notify the Chief of the Military District of the termination of hospitalization. Such notification in the Far East Command will be as follows: For personnel hospitalized in -

JAPAN: Notify CG, Eighth Army, ATTN: AG-RDA
RYCOM: Notify CG, RYCOM, ATTN: Office of Reserve Officers
MARBO: Notify CG, MARBO, ATTN: Office of Reserve Officers
PHILCOM(AF): Notify CG, PHILCOM(AF), ATTN: Office of Reserve Officers

X. Medical Field Service School

A conference held recently at the Medical Field Service School, Brooke Army Medical Center, Ft. Sam Houston, was attended by representatives of the Army field forces of the six Army Areas and senior Organized Reserve Corps instructors who conferred on ORC training needs and viewed Medical Department educational facilities available at the school.

Welcoming addresses were made by Maj. Gen. E. A. Noyes, Commanding General of Brooke Army Medical Center, and by Maj. Gen. Joseph I. Martin, Commandant of the Medical Field Service School. Lt. Col. John M. Gracie, from the Office of the Surgeon General, U. S. Army, Washington, D.C., discussed training from the viewpoint of the Surgeon General.

In open forum discussions prevailing throughout the conference an exchange of ideas between ORC representatives and Medical Field Service School departmental heads clarified the future reserve training program and the educational facilities available in the study of medicine and surgery, preventive medicine, administration, and other Medical Department subjects.

XI. Medical Library to Discontinue Index-Catalogue

The Army Medical Library has decided to bring the Index-Catalogue to a close. Following publication of the volume currently in preparation, the Library plans to publish a volume or volumes which will make the record of its monographic holdings complete up to the mid-century mark; and, beyond that, to publish selectively the most useful portion of the vast backlog of over 1,750,000 yet unpublished references which have accumulated over the years.

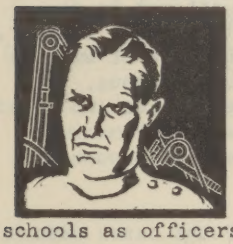
At the same time, the Library's Current List of Medical Literature will be augmented and improved in such a manner as to provide more effective service. An author index will be added; a standard list of journals to be covered regularly will be introduced; classification by broad journal groupings will be abandoned; the format and frequency of publication may be altered; and a cumulative subject index will be provided.

Provision for a continuing record of the Library's monographic holdings has been assured in the form of an annual supplement to the Library of Congress Catalog of Printed Cards.

The Index Catalogue was planned in the mid-19th century when medical research and the publication resulting from that research had an altogether different character from that of the mid-20th century. New fields have opened; millions of dollars have been poured into organized medical research, and as a consequence the literature has increased explosively. This greatly increased publication has had to be forced into a device which was intrinsically non-current; the alphabetical sequence of publication made it necessary to defer publication of many entries until twenty years and more had elapsed, thus greatly diminishing the social utility of the work.

The Army Medical Library believes that its work must be much more closely integrated with current medical research. It is and will continue to be a center of historical research in the medical sciences, but it cannot justify its existence by attempting to continue a form of publication which is no longer feasible.

XII. Army Senior Dental Student Program



A total of 202 selected dental students have been appointed second lieutenants in the Medical Service Corps Reserve and placed on active duty in 36 dental schools under the Army Senior Dental Student Program.

This year the Army Medical Department was authorized to tender commissions as second lieutenants in the Medical Service Corps Reserve to 300 selected dental students who are matriculated in dental schools approved by the Department of the Army. Under the program these students are permitted to continue their studies in their respective schools as officers on active duty with full pay and allowances until they complete the academic requirements for the degree of Doctor of Dental Surgery or Doctor of Dental Medicine.

Upon completion of their dental education these officers will be appointed as first lieutenants in the Dental Corps Reserve and serve on active duty at an Army installation for two years.

XIII. Atomic Medicine Course Opens at Jefferson Medical College - DA SGO, Technical Information Office

The first organized course in the medical aspects of atomic energy was formally opened on 8 February 1950 at Jefferson Medical College, Philadelphia, Pa., in the presence of most of the faculty and student body of the college, and invited guests. Opening the course was a lecture on "The Problem of the Physician in an Atomic Disaster", by Colonel James P. Cooney, Army Medical Corps officer, who is chief of the Radiological Branch, Division of Military Application, Atomic Energy Commission, and consultant in radiology to Major General R. W. Bliss, Army Surgeon General.

Colonel Cooney delivered a message from Major General George E. Armstrong, Deputy Surgeon General, in which he hoped that other leading medical teaching institutions would follow Jefferson's lead by placing a similar course in their curricula, and pledging the "wholehearted cooperation" of the Army Medical Department.

The course, to be repeated annually, will consist of 18 hours of instruction to students on the junior level, with 14 hours to be given by the Departments of Radiology, Medicine, and Surgery of Jefferson Medical College. The other four hours will be given by Army experts in atomic medicine. These, in addition to Colonel Cooney, will be Lt. Colonel Larry Smith, professor of military science and tactics at Jefferson, and Major Gerald M. McDonnel, chief of the Medical Branch, Radiological Defense Division, Armed Forces Special Weapons Project.

Colonel Cooney's talk, profusely illustrated with slides, placed the students in the position of a group charged with planning the medical defense against a Hiroshima-type explosion. The casualties,

he said, would be of three different kinds, resulting from blast, burns, and radiation. The direct blast effect of the Hiroshima bomb was "rather insignificant," Colonel Cooney reported, causing "about a hundred ruptured ear drums, and no cases of trauma to the lungs or ruptured viscera." The indirect effect, however, "was tremendous" and was manifested by flying debris, masonry, timbers, and glass fragments.

Although few serious injuries were found as a result of the blast, Colonel Cooney said, "we know that serious injuries did occur, but unfortunately no effort was made to evacuate the wounded, and those persons unable to walk out of the area were burned to death by fires. The failure to rescue thousands of wounded people in such a situation must not happen here," he insisted. "The public must be given the facts about the measures which can be taken to minimize casualties and suffering. We must not unduly frighten people to the extent that they will refuse to participate in rescue attempts."

Burn casualties, the Army expert said, will be divided between those caused by the flash and those resulting from flames. Beyond 1,000 yards, clothing "offered considerable protection against flash burns," Colonel Cooney said. Color and tightness of the clothes were factors; loose, light clothing provided more protection than tight, dark raiment. Also, individuals exposed to the flash will be temporarily blinded, he told the medical students.

The problem of caring for thousands of thermal or flame burn patients will be "a challenge to the ingenuity and resourcefulness of American medicine", the speaker warned, reminding his audience that the burns resulting from the Coconut Grove night club fire heavily taxed the medical facilities of Boston, "one of the leading medical centers of the world". Therefore, Colonel Cooney asserted, "it is essential that serious consideration be given to appropriate procedures for the mass treatment of thermal burns."

The third hazard, ionizing radiation, is the one which makes the atomic bomb distinctly different from a conventional bomb, the Army doctor said. "Let us not underestimate nor attempt to debunk the radiation hazard. The deaths from ionizing radiation at Hiroshima amounted to 9,000. However, the emphasis placed on it has confused and frightened people to the extent that many believe it will be dangerous to enter a bombed community and rescue the wounded. This is unfortunate and erroneous, Col. Cooney insisted. "We cannot emphasize too strongly that the initial problem is the evacuation and treatment of the blast and burn casualties. After the detonation of an atomic bomb, such as at Hiroshima and Nagasaki, it is perfectly safe to enter the area and rescue the wounded without fear of exposure to residual radiation."

The Army radiologist concluded his talk with a technical medical analysis of the cases seen in Japan.

(ED'S NOTE: See "Psychological Factors in Atomic Warfare," S.C.L., Oct 1950, page 11)

XIV. Recent Department of the Army and FEC Publications

AR 350-101, 24 Jan 50, C-2, Corrected Copy - Professional Education and Training for MD Officers

AR 600-550, 3 Feb 50, C-5 - Deceased

AR 345-415, 3 Feb 50, C-6 - Daily Sick Report

AR 40-410, 15 Feb 50 - Armed Forces Institute of Pathology

AR 140-120, 20 Feb 50 - ORC. Physical Examinations

DA CIR 9, 20 Feb 50 - Liner, Tent, Surgical Operating Truck and Tent, Sectional Hospital

SR 40-590-30, 15 Dec 49 - Subsistence in Hospital Messes

SR 40-530-50, 19 Dec 49 - Herniated Nucleus Pulposus Treatment and Disposition of Patients

SR 135-175-4, 3 Jan 50 - Release of officers and warrant officers from extended active duty. Par 5 b, Final type physical examination

SR 350-350-20, 6 Jan 50 - Army Officer Candidate Courses, Male Candidates. Par 4 (e) Physical Exam

SR 50-140-10, 11 Jan 50 - Insect and Rodent Control Operations

SR 35-210-20, 20 Jan 50 - Finance and Fiscal: Army Fiscal Code: Working Funds - Fiscal Year 1950. Par 5, Working Fund Accounts - FY 50. Symbol 2105908, Working Fund, Army, Medical, 1950

SR 40-220-10, 31 Jan 50 - Physical Examination of Civilian Employees

SR 605-150-40, 2 Feb 50 - Dental Military Residency Training

SR 700-140-2, 2 Feb 50 - Hearing Aids

SR 140-180-15, 3 Feb 50 - ORC. Administration of Benefits Provided by Sec 5 of Act of 3 Apr 39, as amended, as Further Amended by Act of 20 Jun 49, for Members who Suffer Injury or Death in Line of Duty while on Active Duty or in Reserve Duty Training. (ED'S NOTE: See Sec IX, page 6, this issue)

SR 40-210-10, 8 Feb 50 - International Certificate of Inoculation and Vaccination

SR 40-320-5, 21 Feb 50 - Inspection of Certain Parenteral Solutions

RT 8-510-20, 16 Dec 49 - Field Hospital (Active Army)

RT 11-15N-22, 1 Jan 50 - Signal Bn, Corps (NG); Sec II B. Medical Detachment, Signal Bn Corps; Sec III, Equipment, Medical

TB MED 202, Jan 50 - Allergy; Supersedes TB MED 202, 15 Oct 45

TB MED 186, 16 Feb 50 - Moisture-Proofing and Fungi-Proofing (Tropicalizing) MD Equipment. Supersedes TB MED 186, Jul 45

T/A 20-79, 28 Nov 49 - United States Army, Marianas-Bonins Command. Page 17, Medical

GHQ SCAP CIR 3, 3 Feb 50 - Control of Entry and Exit of Individuals, Cargo, Aircraft, and Surface Vessels into and from Japan. Sec VI: Quarantine; Par 29, Immunization Requirements; Par 33, Required Procedures for Specific Diseases; Par 36, Dead Bodies Aboard Vessels or Aircraft; Par 37, Requirements for Individuals Departing from Japan

GHQ CIR 5, 11 Feb 50 - Medical Gen Lab Service. Rescinds GHQ CIR 69, 13 Jan 47, GHQ CIR 106, 14 Nov 47

GHQ CIR 9, 27 Feb 50 - Immunization. Rescinds GHQ CIR 8, 2 Mar 48

GHQ SCAP CIR 4, 6 Mar 50 - Consumption of Japanese Food Products

PART II

TECHNICAL

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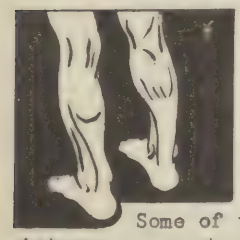
Problems of Insect Control in Military Units During the Occupation of Japan - An Abstract	XVIII	15

XV. The Role of Vascular Disease in the Production of Chronic Skin Ulceration of the Lower Extremity - Lt. Colonel Sanford W. French, III, MC, 118th Station Hospital, APO 24-5

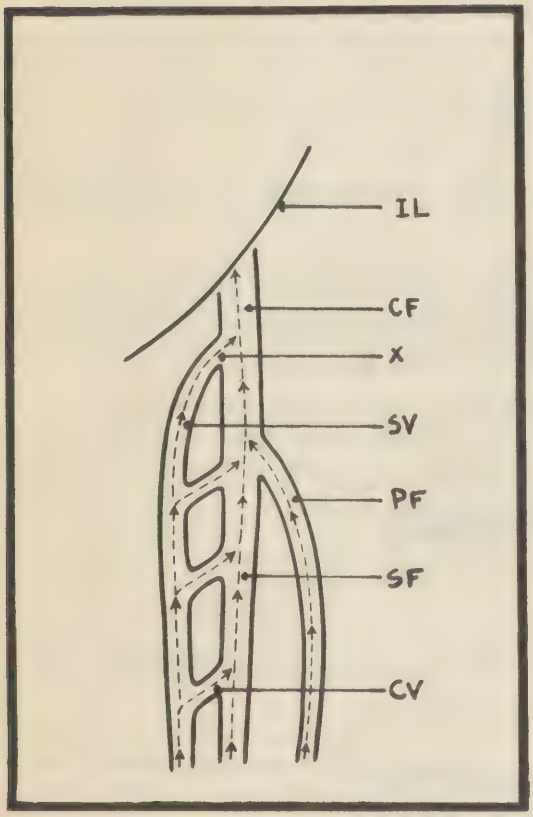


Chronic skin ulceration of the lower extremity is a condition frequently met. Many forms of treatment have been advocated for the cure of these ulcers without regard to their etiology, pathologic anatomy and physiology. Many patients run the gamut of vein ligation, sclerosing agents, various salves and ointments, chiropractic treatment, massage, x-ray, ultra-violet and quartz lamp therapy, etc., only to see their ulcers progress to a state causing partial or complete disability, to say nothing of the psychic trauma involved over a long period of years.

Some of the etiological factors concerned with the production of these ulcers and their persistence are: chronic venous insufficiency or stasis, vasospastic states, burns, bacterial infections, fungus infections, trauma, neurogenic conditions, the granulomatous diseases, diabetes mellitus, and syphilis. As Byars and Letter man (1) emphasize, predisposing factors which will prevent or prolong proper healing of these ulcers are anemia, hypoproteinemia, chronic shock, foci of infection (teeth, sinuses, etc.) and general debilitation.

This paper is concerned primarily with the role played by chronic venous stasis and vasospastic conditions in the production of chronic leg ulcerations - by far the most common causes of this distressing condition.

FIG 1



Normal flow of blood up the thigh when all valves are competent.

IL - inguinal ligament; CF - common femoral vein; X - sepheno-femoral junction; SV - saphenous vein; PF - profunda femoris vein; SF - superficial femoral vein; CV - communicating vein.

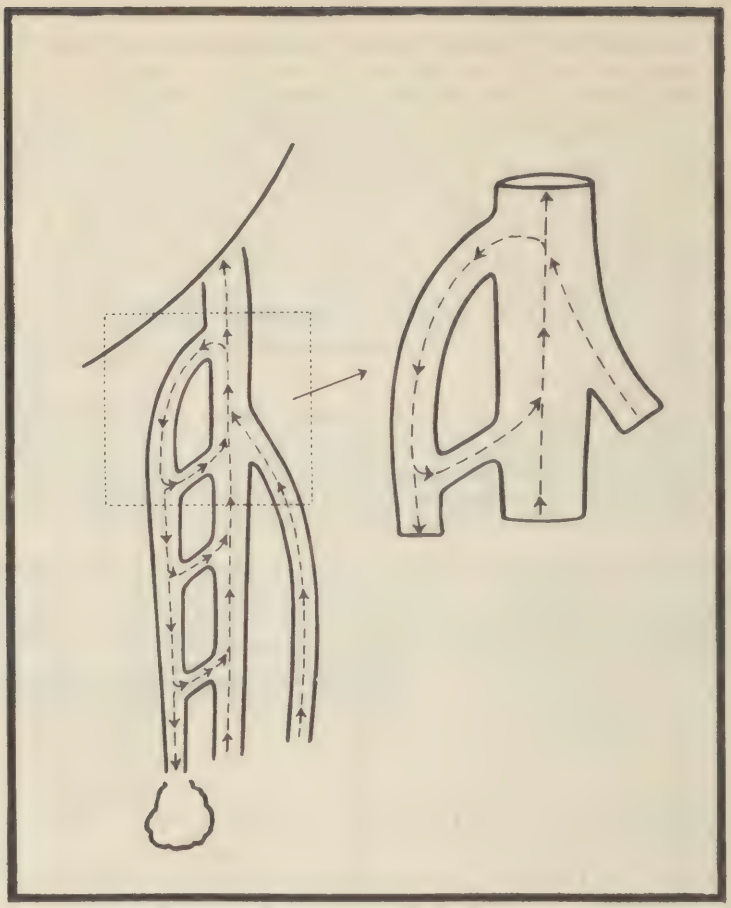


Diagram of the flow of blood when the valves within the saphenous vein are incompetent. The valves in the communicating veins being competent, the only "spillage" or reversal of flow occurs at the sapheno-femoral junction. This gives rise to the "circus actior" flow of blood between the saphenous and the superficial femoral systems (inset) in the counter-clockwise direction. Ulcers caused by this type of pathology are usually of the varicose type and respond to saphenous resection alone.

FIG 2

FIG 3

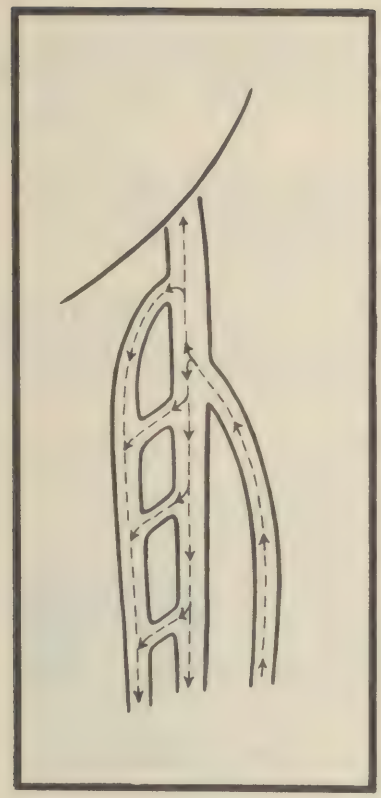


Diagram of the flow of blood when the valves within the Saphenous vein and the communicating veins are incompetent. The clinical picture presented here in addition to ulceration is usually one of severe varicose veins due to the added increase in venous pressure within the saphenous system due to retrograde flow through the communicating veins from the superficial femoral system. Pathology of this nature usually responds to complete saphenous resection.

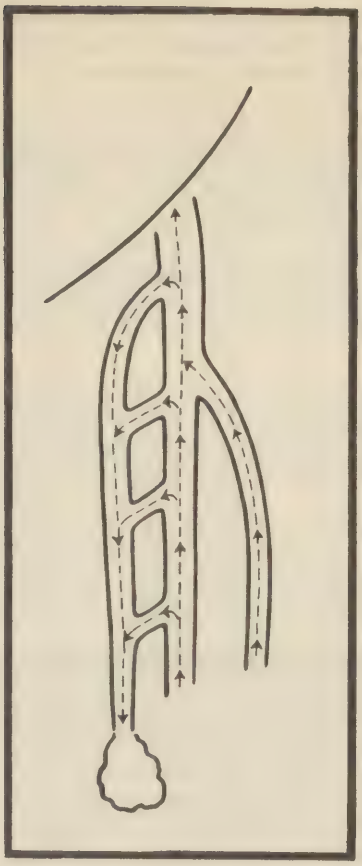
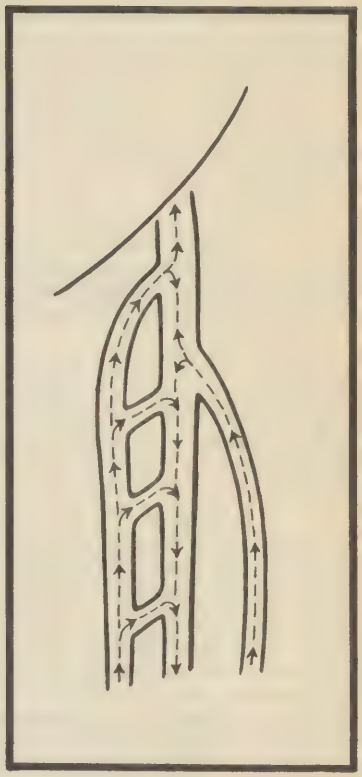


Diagram to show flow of blood when valves in the saphenous, the communicating veins and the superficial femoral system are incompetent. The clinical picture presented here is one of severe varicose veins, edema of the leg, particularly about the ankle, ulceration, pigmentation, and discoloration, etc. Minimal treatment required would be saphenous resection and section and ligation of the superficial femoral vein just distal to the junction of the latter and the profunda femoris. If vasospasm is present, lumbar sympathectomy is indicated. Many cases of this type require skin grafting.

FIG 4

FIG 5



Flow of blood when only the valves in the superficial femoral system are competent. The clinical picture presented here is one of ulceration without evidence of varicosities or if varicosities are present, they are minimal. One would think that ligation and section of the superficial femoral vein alone effect a cure. Actually this is not the case because there would still be a retrograde flow of blood through the superficial femoral vein coming through the communicating veins from the saphenous. This type of pathology therefore requires saphenous resection and ligation and section of the superficial femoral vein.

Pathologic Anatomy and Physiology:

Most texts on anatomy rightfully describe two venous systems of the lower extremity - a superficial (saphenous) and a deep (femoral). For reasons which will be apparent to the reader later, I should like to further divide the deep (femoral) circulation into two systems: the superficial femoral and the profunda femoral systems. (Fig. 1)

Personal experience has proven that simple high ligation of the saphenous vein will offer at best only a temporary relief of the symptoms of varicose veins. This is because the valves in the communicating veins soon become incompetent, giving rise to a "circus action" flow of blood through the saphenous and superficial femoral systems (Fig. 2).

For complete and permanent results, the saphenous vein should, in practically all cases, be resected in its entirety from the groin down to the internal malleolus of the ankle, ligating all communicating veins as they are encountered. Sclerosing agents have no part in the treatment of chronic leg ulceration.

Many cases of chronic phlebitis of the superficial femoral system without any history whatsoever of an acute episode of phlegmesia alba dolens have incompetent valves in this system. This leads to backflow of blood from the profunda system at the junction of these two veins into the superficial femoral system which, in turn causes venous stasis in the latter system (Figs. 4 and 5).

The venous stasis and increased venous pressure in either of these two systems (asphenous and superficial femoral) naturally leads to increased back pressure within the venules and capillaries, slowing of circulation, anoxia of the vessel wall, increased permeability of the vessel wall, and this, with the increased intraluminal pressure finally leads to chronic edema of the tissues of the leg, skin pigmentation and ulceration.

Many cases of chronic superficial femoral vein phlebitis have in addition to incompetent valves, an associated vasospasm because of overactivity of the sympathetic nervous system. This reflex mechanism acts on the arterioles and venules by constricting them causing in turn an increased filtration pressure within the vessel, slowing of circulation, anoxia of the vessel wall, increased permeability of the vessel wall and this, in conjunction with the increased intraluminal pressure also leads to edema of the leg, pigmentation, ulceration, etc. Usually other signs and symptoms of vasospasm are present such as increased sweating of the foot and leg (from direct sympathetic stimulation of the sweat glands); a bluish mottling of the skin on exposure to cold; a cold, clammy foot; calf pain on exercise; delayed capillary refilling time, etc. This is a common condition associated with chronic ulceration of the lower extremity and will require sympathectomy. Procaine lumbar sympathetic blocks at best offer only temporary relief and are in no way curative due to the long duration of the disease.

Finally, there is the ulcer which has been present for many years in which the tissues are bordering on a state of gangrene due to the prolonged anoxia and edema which has persisted. This type of ulcer will usually require skin grafting in addition to other measures.

In effect then, the four main forms of therapy of chronic ulceration of the skin of the leg due to vascular insufficiency are: complete saphenous resection, division and ligation of the superficial femoral vein, lumbar sympathectomy, and skin grafting.

General Management:

A careful history is most important. Pain caused by varicosities of the saphenous or superficial femoral systems usually comes on while the patient is standing or sitting and not engaged in physical activity or it may be described as an aching in the legs after the patient has gone to bed. Pain caused by vasospastic conditions usually comes on during physical activity. Both types of pain may be present in the same patient.

After having ruled out other than vascular causes for the patient's ulcer, his general health is checked and any anemias, hypoproteinemias or foci of infections are corrected. He is then made a strict bed patient and the affected leg elevated about 15 degrees. If the edema subsides rather quickly, a vascular etiology should be suspected. If edema subsides slowly, lymphedema may be a factor. Clean, dry, dressings only are kept on the ulcer. If an epidermophytosis of the feet or fungus infection of the nails exist they are treated with 1:5000 potassium permanganate solution or in severe cases the nails are excised. Many ulcers heal under this regime but when this occurs, treatment should not be interrupted. After healing of the ulcer or after it has been cleared up as well as possible, the patient's leg is wrapped carefully with an ACE bandage up to the knee, and he is allowed to be ambulatory. If ulceration, edema and pain do not recur following ambulation with the leg wrapped, a saphenous resection

is then performed. In cases with a long history of large chronic ulcer, skin pigmentation and severe edema, we routinely perform saphenous resection and superficial femoral ligation concomitantly. The only contraindication to this procedure, as Linton (2) has pointed out, is an abnormally high venous pressure in both systems at time of operation. In such a case, two separate operations are performed allowing a time interval for collateral venous return to become well established.

Lumbar sympathectomy is usually done as a later procedure, if indicated, although I have on one occasion performed saphenous resection, superficial femoral ligation and section, lumbar sympathectomy and skin grafting concomitantly with rapid and gratifying healing of the ulcer.

Split thickness skin grafting must usually be resorted to in cases of large chronic ulceration of long duration with much pigmentation and discoloration of the skin. This, like sympathectomy is usually reserved for a later operation but if sound clinical judgment and experience dictate concomitant grafting, this should be done.

SUMMARY:

1. The etiology, pathologic anatomy and physiology of chronic skin ulceration of the leg is discussed.
2. The main therapeutic surgical measures to be employed in the treatment of these ulcers are complete saphenous vein resection, superficial femoral vein section and ligation, lumbar sympathectomy and split thickness skin grafting.

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1. Byars, L.T., and Letterman, G.S., Surg. Gny. Obst. 1949, 89:583
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XVI. The Treatment of Hepatic Amebiasis with Chloroquine - Colonel Robert E. Blount, MC, Medical Consultant, Far East Command

Out of the wartime antimalarial drug research program came several active compounds of the 4-amino-quinolin series. Chloroquine[1] proved one of the most active and less toxic members of this group. Chloroquine was found: (1) to be extensively localized in the liver after oral ingestion, to some 500 times its plasma concentration[2]; (2) to be localized to a much less extent in the intestinal wall; and (3) to be almost completely absorbed from the intestinal tract. Since only 8% of the daily dose is excreted in the feces, the contents of the intestinal lumen, especially the colon, contain a rather small drug concentration.

Conan[3] has shown that clinically chloroquine is highly effective in the therapy of extra-intestinal amebiasis, especially amebic hepatitis. It is a much less toxic drug than emetine, which is perhaps even more effective against extra-intestinal amebiasis. Parmer[4] as well as Smith[5] have shown that emetine is concentrated especially in the liver much as is chloroquine. Neither emetine or chloroquine are as efficient intestinal antiamebicidal drugs as are such preparations as carbarsone, diodoquin, or chiniofon. Emetine, for instance, although highly effective against the extra-intestinal amebiasis, will succeed in eliminating permanently the ameba in only 10-15% of cases of colitis. The iodohydroxyquinolines, on the other hand, are said to be effective in 70-90% of intestinal infections, but are without effect on extra-intestinal infections.

Emetine occasionally does cause serious toxic effects and must be used with caution. Recent studies[5] have shown that electrocardiographic changes frequently occur during emetine therapy. Chloroquine is probably as effective in extra-intestinal amebiasis, and is a considerably safer drug for amebic hepatitis. It may subsequently prove to be the drug of choice, especially for amebic hepatitis.

Because it is clinically impossible to determine with accuracy in every case of intestinal amebiasis whether or not extra-intestinal involvement has occurred, and because of the high frequency of such metastatic infection observed in pathologic material, it is at least theoretically highly desirable to treat every patient with intestinal amebiasis with agents designed to eradicate amebae wherever they may be in the body. Until now emetine has been the only available agent for extra-intestinal amebiasis whereas there are several fairly efficient intestinal amebacides. The toxicity of emetine and the measures designed to minimize or present such toxicity have precluded the widespread practical application of the above principle. Since the lack of toxicity of chloroquine permits treatment of even ambulatory patients, Conan recommends that chloroquine be employed in addition to a more efficient in-

testinal amebacide for the treatment of all cases of intestinal amebiasis. Conversely, for the treatment of hepatic amebiasis, even in the absence of signs or symptoms of intestinal involvement, it is recommended that an intestinal amebacide be employed in addition to chloroquine in order to be more certain to eradicate any colonic focus of infection, because chloroquine is only about 50% curative for intestinal amebiasis.

DOSAGE:

Conan tried chloroquine in the following dosage for extra-intestinal amebiasis: Chloroquine diphosphate 1.0 gram daily for 2 days, followed by 0.5 gram of chloroquine diphosphate daily for 2 or 3 weeks (1.0 gram of the chloroquine diphosphate is equivalent to 0.6 gram of chloroquine base). Conan concluded the combination of chloroquine with a superior intestinal anti-amebic drug would permit adequate treatment of any amebic infection, and should permit wider use of anti-amebic chemotherapy as a diagnostic and therapeutic test in obscure infections of the liver and intestine.

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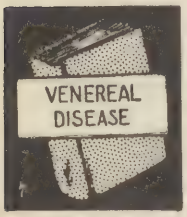
4. Parmer, L.G. On the relative efficacy of emetine in intestinal and hepatic amebiasis. Proc.Soc. Exper.Biol. & Med., 68:362, 1948
5. Smith, P.K., et al, The Tissue distribution and toxicity of emetine. Federation Proc., 7:256, 1948

XVII. Chancroid and the Granuloma's - Maj. Louis N. Altshuler, MC. Presented at Eighth Army Medical Conference, 35th Station Hospital, Kyoto, Japan



Interest is again aroused in the chancroidal lesions because of the apparent relative frequency of such lesions in our troops here in Japan. This situation parallels the experience of Walker and his co-workers in the post armistice period in Europe in World War I. At that time it was noted that the proportion of chancroid to other venereal infections rose beyond the ordinary relative proportion of this variety of infection, for the reason that prophylaxis as practiced had less effect upon chancroidal infection than it had upon syphilitic and gonorrheal infections.

Since August there has been a 25% increase in the rate of chancroidal infection among Army troops in Japan. During the month of August there were 296 cases diagnosed as compared to 479 cases diagnosed in September. It may be explained by the fact that there is a higher degree of suspicion and a tendency to diagnose on the basis of clinical evidence alone since the bacteriologic examination is notoriously unreliable. In a discussion of this situation with the Commanding Officer of the 406th Medical General Laboratory, he stated that they have tried to culture the Ducrey for two years and have been unsuccessful. For a period of time they doubted the existence of the B. Ducrey.

We have recently skin tested over 120 men who had been diagnosed as chancroid by smear or clinical evidence and found 36 positive, or 24% that could be confirmed. The others showed a negative skin test which excluded chancroidal infection.

The facts concerning the etiology, methods of diagnosis and treatment of syphilis and gonorrhea have reached a state of reasonable accuracy. Less attention, however, has been devoted to the other venereal diseases. Part of this defect undoubtedly stems from the peculiarities of the respective etiological agents, none of which as yet readily lends itself to what might be called routine laboratory procedures.

The need for diagnostic aids has become increasingly apparent to those of us engaged in venereal disease control, because sad experiences have shown that clinical differential diagnosis alone is far from certain. Not only may the lesions of these diseases be confused inter se, but syphilis itself must be ruled out. A bubo of supposed lymphogranuloma venereum may yield the gonococcus on culture. Rectal strictures and genital elephantiasis may be brought about by the unsuspected virus of lymphogranuloma venereum. Add to these uncertainties, the well founded observation that many of these patients have, or have had, various combinations of all venereal diseases and the resultant confusion becomes apparent. The tragedy is seen when therapy is initiated in a case of erroneous or incomplete differential diagnosis based on the clinical picture alone. This becomes increasingly important from

a military standpoint since charging a man with venereal infection when it does not exist may prove to be an injustice to the individual. I have reference to present directives that provide for the elimination from the service of individuals who are chronic repeaters and reduction of non-commissioned officers for the same reason.

The diagnosis of chancroid is too commonly made on the clinical characteristics and response under treatment. The possibility of a mixed infection with syphilis should not be overlooked. The dictum that every genital lesion should be suspected as being syphilitis until proved otherwise by repeated darkfield examination and serologic follow-up should be followed. In 1920 Teague and Derbert cultured some 274 penile ulcers, 140 yielded positive Ducrey cultures. Of the 134 negative cases, satisfactory notes were obtained on only 69 and from these notes it is apparent that 42 of these 69 negative cases at least were not chancroidal but primary syphilitic lesions. The diagnosis of chancroid may be accepted if the signs and symptoms are typical and if repeated search for T. Pallidum, Donovan bodies, Frei tests and serologic tests for syphilis yield negative results and the Ito skin test is positive.

Intradermal Chancroidal Test. (Ito-Reenstierna Reaction)

Greenblatt and Sanderson have called attention to a very valuable method of excluding or including chancroidal infection. This test is frequently referred to as the Ito-Reenstierna Reaction and is a diagnostic procedure commonly used in European clinics. The delay in adoption of this test in the United States has been due to the difficulty in developing bacillary vaccine from strains of American origin. The credit for developing reliable strains is due to the excellent work accomplished at the University of Georgia School of Medicine. With this bacillary antigen, it is possible to make the diagnosis completely and accurately. A negative intradermal test is diagnostic insofar as it rules out infection by the bacillus of Ducrey.

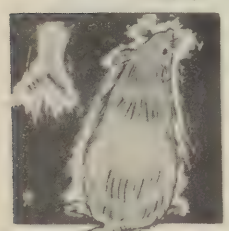
Lymphogranuloma Venereum is more prevalent than supposed and should not be confused with granuloma inguinale, which begins with an infection of the skin and mucus membranes. Lymphogranuloma venereum is due to a filterable virus and presents a somewhat similar clinical picture but is easily differentiated by means of the Frei test.

Granuloma Inguinale is usually considered to be of venereal origin, although in some cases there is no evidence of sexual contact. The organism seen in direct smears by Donovan are now accepted as the cause of this infection (Donovan Bodies). The Wright or Giemsa stain may be used to demonstrate these bodies.

Comments by Colonel R. E. Blount, MC, Medical Consultant, Far East Command:

The intradermal chancroidal test is a useful addition to our means of identifying the venereal diseases. Two points should be kept in mind: (1) The intradermal test is not likely to become positive until the regional lymph nodes become involved. This usually represents an elapsed time of 8 - 10 days; (2) Once positive the intradermal chancroid test remains positive.

XVIII. Problems of Insect Control in Military Units During the Occupation of Japan - An Abstract - Lt. Colonel Joseph E. Webb, Jr., MSC, Medical Section, Headquarters Eighth Army



Insect control measures during the early months of the occupation in Japan involved large scale use of aircraft for dispersal of DDT insecticides. Pre-invasion and post-invasion DDT applications by air in the Philippines, Marianas and Ryukyus had been a military necessity. The same troop commanders upon entering Japan, in anticipation of epidemics of insect-borne diseases and accustomed to relying heavily on aircraft spraying, utilized that method of control extensively. Need for protection of the health of troops at that time outweighed consideration of the possible damage to Japanese economy by airplane dispersal of DDT. By the latter part of 1946 it became evident to scientists, American as well as Japanese, that continued large scale and rather poorly directed applications of DDT by aircraft would incur extensive damage to the Japanese economy by decimating sericulture as well as damaging fish and beneficial insect life.

Early in the occupation it was realized that the mosquito control problem in Japan necessitated an intensive ground control program rather than airplane spraying as the primary procedure. Most of the insecticide being applied by the air was landing on rooftops, streets and open, well-drained areas, while the breeding of mosquitoes and flies, in their usually well protected habitats, continued unabated. In occupation units, screening and thorough DDT residual spraying was of utmost importance.

Although some control of mosquitoes and flies in Japanese civilian areas is effected each season by Japanese sanitation teams under the surveillance of Civil Affairs personnel, these measures are often far from adequate. Civilian areas adjacent to facilities utilized by occupation forces are a constant source of infestation. In metropolitan areas mosquito breeding is prevalent in many types of artificial containers, such as drainage ditches, bombed-out buildings, receptacles in cemeteries, etc. In rural and urban areas additional breeding places are rice paddies, irrigation ditches, night soil storage tanks, etc. Night soil receptacles teeming with fly maggots are a common sight in Japan. Artificial containers holding water to be used for watering gardens and for diluting the night soil for fertilization are sources of mosquito breeding throughout the summer. Japanese agriculture has been so vitally dependent upon night soil storage pits and the "honey-bucket" in the conservation and utilization of night soil, that control of fly and mosquito breeding cannot possibly be adequately accomplished without individual action by each farmer. In some instances close cooperation between Army supervisory personnel and Civil Affairs Public Health officials result in a fairly effective program in areas adjacent to the occupation facilities. Observation of the operations of Japanese civilian sanitation teams in many areas and the common insanitary practices of the families and communities indicate that there is often little importance attached to the need to control such pests as mosquitoes, flies and rats.

One night catch of rats in the vicinity of the Tokyo General Hospital, Tokyo, Japan

In July 1946, directives were issued requiring that before any area was approved for airplane spraying, the probable effect of DDT on the natural resources of the area be evaluated, to include particularly the effect on sericulture, fisheries and agricultural crops. If damage to those natural resources was likely to be appreciable, airplane spraying was prohibited.

In March 1947, General Headquarters in Tokyo announced that beginning with the fiscal year 1948, responsibilities for conducting insect and rodent control activities would be in accordance with TM 5-600, November 1945. This directive made the Corps of Engineers responsible for effecting control measures. In early July of that year, Mr. S. C. Dews, entomologist, was assigned to supervise, for the Eighth Army Engineers, the organization of insect and rodent control procedures as an engineer function throughout Eighth Army units. In April 1947, the writer had been assigned as Entomologist for the Medical Section, Headquarters Eighth Army. These two, operating as a team, began to organize and develop an insect and rodent control program, conducted by regional post engineers, to protect the health and

morale of Eighth Army forces, with a minimum of airplane spraying. Unfortunately, the developmental phase of this program had to take place during the summer months when an efficient operating program should already have been in operation.

Initially, the engineer program called for a technically trained civilian insect and rodent control supervisor on the staff of each regional post engineer; however, the unavailability of qualified civilian personnel in Japan made it necessary to assign untrained enlisted men to these jobs. There is no table of organization position and thus no "career field" established for an enlisted insect and rodent control supervisor on the post level. This means that there is no real incentive for a soldier in that field of work and usually results in an undesirable rapid turnover of enlisted supervisors.

For this reason the essential phases of program development have been the conducting of training courses for enlisted insect and rodent control supervisors and also semi-annual visits to all regional posts, sub-posts, hospitals, etc., to give on-the-job training and assist in all technical aspects of the program. These two functions have been carried out jointly by entomologists of the Engineer and Medical Sections of Eighth Army and General Headquarters. The development of the program is reflected to some degree in the progressive increase in attendance at the training courses which are attended by the insect and rodent control supervisors from all posts, sub-posts, and hospitals, as indicated in the following table. Recent courses were also attended by post medical inspectors.

ATTENDANCE AT TRAINING COURSES

Date of School	Number of Sessions	Total Attendance
Nov 1947	1	37
Apr 1948	1	55
Oct 1948	2	63
Apr 1949	2	88
Oct 1949	2	124

Training provided at these courses includes a maximum of practical demonstrations of post problems. It is contemplated that future schools will be conducted in smaller groups so the training will be more personalized and the demonstrations more effective. Two existing malaria control detachments have been used to give technical direction to the engineer programs in Yokohama and Kobe Base.

A control team consisting of one enlisted man and several Japanese laborers is organized in each hospital as a part of the hospital utilities section. These crews usually work independently of the regional post engineer, but obtain necessary supplies and equipment from them. This arrangement results in an excellent program at all hospitals. The regular post engineer crews on posts and subposts ordinarily consist of one to four enlisted men and five to fifty or more Japanese laborers, depending upon the size of the post and additional areas to be controlled.

Twenty-four regional post engineers are responsible for the insect and rodent control programs, including requisitioning and distribution of necessary vehicles, supplies, equipment and personnel, for all Eighth Army units. The post engineer trained crews actually accomplish residual spraying, area larviciding, rat proofing, handling poison baits, rat-trapping, etc., in all buildings utilized by the occupation within a radius of several miles of the posts or headquarters. Many small units, such as Civil Affairs Teams, CIC Teams, CID Teams, rest hotels, etc., which are located in remote areas of Japan, frequently at great distances from the larger military units, have their own insect and rodent control teams. The regional post engineer having responsibility for these smaller units, furnishes needed supplies and equipment and on-the-job training as needed to provide a proper functioning team. Many post engineers hold training courses to instruct personnel from these outlying units. Additional on-the-job instruction is provided by visits to those outlying units by an entomologist from corps or army headquarters.

Larviciding

A truck-mounted power fog and dust dispersing machine was used during the 1949 season in Yokohama. This machine delivers a mist of DDT solutions or cloud of dust at high velocity which drifts through poorly sanitated Japanese civilian areas as well as the military areas concerned. This procedure effects mosquito larval control to an appreciable degree and also greatly reduces adult populations of flies and mosquitoes. Additional units of this equipment have been obtained by the Engineers and will be in operation during 1950 in several of the greater metropolitan areas. The units can be carefully controlled and the insecticide confined to non-agricultural areas where little or no harmful effects will result. In smaller areas, DDT mists produced by exhaust-type aerosol generators on jeeps or other vehicles are used for limited area control of adult insects.

Cockroach control, although of little consequence during the early years of the occupation, has become of increasing importance during the past two years. This is attributed to the more ideal conditions of temperature and food supply, thus inducing more rapid reproduction and build-up of infestations, than existed before the buildings were utilized by occupation forces. Special attention has been given to training of engineer crews in cockroach control procedures. DDT sprays and dusts have given reasonably good control; however, the new DDT-chlordane preparation will be utilized for this purpose as soon as it becomes available in Japan.

An interesting observation during the occupation is the complete absence of bedbug infestations in army barracks. During the early months of the occupation, entomologists with the U. S. Army observed occasional bedbug infestations in Army housing which had been formerly occupied by the Japanese troops; however, subsequent applications of DDT have effected complete and apparently lasting riddance of this pest. The writer has been unable to find any bedbugs in buildings used by occupation personnel during his three years as entomologist in the Eighth Army Medical Section. This fact is additional evidence of the importance of residual application of DDT as an essential part of the insect control program by and for the occupation forces.

Black flies have been of minor importance as a nuisance in several areas of Japan. Specimens taken biting in the Kyoto area have been identified as Simulium venustum. Satisfactory protection against this biting pest has been obtained by use of insect repellents. Extensive specific control measures have not been indicated.

Insect and rodent control measures effected by engineer teams have been closely coordinated with entomological surveys at major installations in Eighth Army each season. Trained personnel have not been available to make surveys on a weekly or even a monthly basis in all areas; however, the one malaria survey detachment has been utilized to make seasonal surveys in areas of greatest troop concentrations in southern Honshu and in Kyushu. Surveys of a more limited nature have been conducted at least once each season at other major installations by entomologists making semi-annual visits from Eighth Army Headquarters. Findings of all surveys have been used as a guide for control operations. In 1949 additional entomologists were available and permitted thorough weekly surveys of mosquitoes in the Tokyo, Yokohama and Kyoto areas.

SUPPLEMENT TO COLONEL WEBB'S DISSERTATION - Major Kermit E. Jones, MSC, Sanitary Engineer, GHQ, FEC

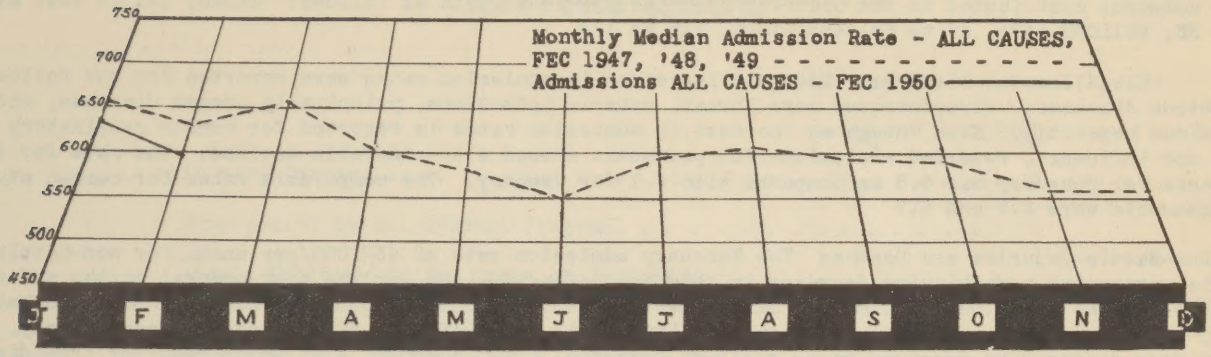
By way of comparison with the foregoing, a summary of control programs in other Far East Command areas may be of interest. In 1946, insect and rodent control was established as an engineer responsibility to become effective July 1947. In the Philippines, civilian crews and supervisors were recruited and trained, the training being conducted on each post separately except in the Manila area where on-the-job training was given at the Headquarters post area. In Okinawa, Philippine Scout medical units were used to supervise Okinawan crews and later Filipino civilians, some who had been Scouts, were used for control foremen and for survey. Schools were conducted for Okinawans and for the corresponding crews in the villages and districts. On Guam, Filipino civilian crews and foremen were utilized and two training schools were conducted, one for the Air Forces and attended by supervisory personnel from Okinawa and the Philippines.

In areas, other than Japan and particularly on Okinawa and in the Philippines, during the period of activity, medical department surveys were conducted on a large scale. This provided an accurate and concurrent guide as to the adequacy and effectiveness of the control program. A more efficient and less expensive program resulted. Control measures were the same in all cases as that carried on in Japan, except that in certain parts of Okinawa and the Philippines, airplane spraying was feasible and useful.

PART III

STATISTICAL

HEALTH OF THE COMMAND



Admission rates per 1000 troops per annum for the four-week period ending 24 February 1950 were as follows:

	FEC	JAPAN	MARBO	PHILCOM	RYCOM
All Causes	595	662	220	299	490
Diseases	552	617	164	264	464
Injuries	43	46	56	35	26
Psychiatric	9.7	11	2.7	3.9	9.0
Common Respiratory Diseases and Flu	97	117	9.4	27	48
Primary Atypical Pneumonia	2.7	2.9	0	5.8	1.9
Common Diarrhea	3.2	2.9	0	1.9	7.1
Bacillary Dysentery	.34	.22	0	3.9	0
Amebic Dysentery	.34	0	0	0	2.6
Malaria, new	.09	.11	0	0	0
Infectious Hepatitis	5.8	6.9	0	3.9	2.6
Mycotic Dermatoses	1.9	2.5	0	0	0
Rheumatic Fever	.26	.22	1.3	0	0
Venereal Diseases	153	164	35	58	178

The Far East Command all causes admission rate of 595 for February depicts a substantial decrease from the January rate of 638. All major commands experienced a decrease in the above rate which was principally attributable to an overall decrease in venereal disease incidence.

The average daily non-effective rate of 17 remained the same as for the previous month. These rates for the same periods in 1948 and 1949 were 22 and 21, respectively; therefore, the health of the military forces in the Far East Command continues good.

Diseases:

Common Respiratory Diseases and Influenza: Admissions for common respiratory diseases and influenza continued their moderate upward trend with a rate of 97 for February for the Far East Command, as compared with 91 for the previous month. There is still no evidence of a significant occurrence of influenza although the disease has been shown to be present at least in certain areas in Japan. All major commands except PHILCOM(AF) experienced some increases in admission rates from this group of infections, but the major incidence continued to be in Japan where an admission rate of 117 was reported. In Japan, however, the admissions tended to decrease among troops in the vicinity of Tokyo and Yokohama while some increases were noted in certain outlying areas. During the month of February, approximately 100 paired specimens were submitted from occupation personnel in Japan for specific diagnosis of influenza. Almost one-half of these (48) were found to be positive for influenza B. With the exception of

a single instance in December 1949, all the laboratory findings during the current season have indicated that the influenza present in Japan is type B. This is in contrast to the experience being reported from the United States where laboratory studies have shown the presence of influenza A and A prime.

Venereal Diseases: The total Far East Command venereal disease rate of 153 for this month represents a considerable decrease from the previous month's rate of 180. This is the lowest rate since June of last year. The colored component of the rate shows the greatest decline for the month; dropping from 240 in January to 195 and is the first time since December 1948 that it has been below 200. All major commands contributed to the decrease from the previous month as follows: Japan, 191 to 164; MARBO, 40 to 35; PHILCOM (AF), 87 to 58; and RYCOM, 215 to 178.

Miscellaneous Diseases: Moderate increases in admission rates were reported for the following infectious diseases: streptococcus sore throat, enteric infections, principally common diarrhea, and infectious hepatitis. Even though an increase in admission rates is reported for common respiratory diseases and influenza, reported admissions for pneumonia showed a considerable decline. The rate for total pneumonia for February was 4.8 as compared with 8.1 for January. The comparable rates for common atypical pneumonia were 2.7 and 4.7

Non-Battle Injuries and Deaths: The February admission rate of 43/1000/per annum for non-battle injuries presented a continuing decrease in this type of admissions for the past several months and corresponds favorably to the all-time low January rate of 45. In further comparison, the annual non-battle injury admission rates per thousand troops for 1947, 1948 and 1949 were 64, 58 and 51, respectively. Twenty-four deaths were reported among military personnel for the month, 4 of which resulted from disease and 20 from injuries. This is a considerable increase over the 6 deaths resulting from injuries during January, but is less than the monthly average for 1949.

Evacuation:

Tabulated below are the number of patients evacuated from the major commands to the ZI during the four report weeks in February and the number of patients awaiting evacuation as of 24 February 1950:

	BY AIR	BY WATER	TOTAL	PNTS AWAIT EVAC
JAPAN	204	17	221	102
MARBO	6	1	7	8
PHILCOM	28	4	32	17
RYCOM	43	6	49	18
FEC	281	28	309	145

Evacuations of military personnel per thousand strength for the period of 28 January to 24 February were as follows: JAPAN - 1.7; MARBO - .62; PHILCOM - 3.7; RYCOM - 2.2; FEC - 1.8

Hospitalization: The bed status as of 24 February 1950 was as follows:

	Total T/O Beds Auth.	Total T/O Beds Establ.	Total T/O Beds Occupd.	% Auth. T/O Beds Occupd.	% of Establ. Beds Occupd.
JAPAN	4,600	4,228	1,758	38	42
MARBO	200	200	85	43	43
PHILCOM	1,250	1,250	524	42	42
RYCOM	750	443	220	29	50
FEC	6,800	6,121	2,587	38	42

IMMUNIZATION CIRCULAR

Particular attention is invited to the recently published circular on Immunization listed under Section XIV, Recent Department of the Army and FEC Publications, this issue. This circular (GHQ FEC CIR 9, "Immunization", 27 Feb 50) replaces Circular No. 8 of 2 March 1948. All medical officers and others responsible for administrating immunizations should become completely familiar with the provisions of this new publication.

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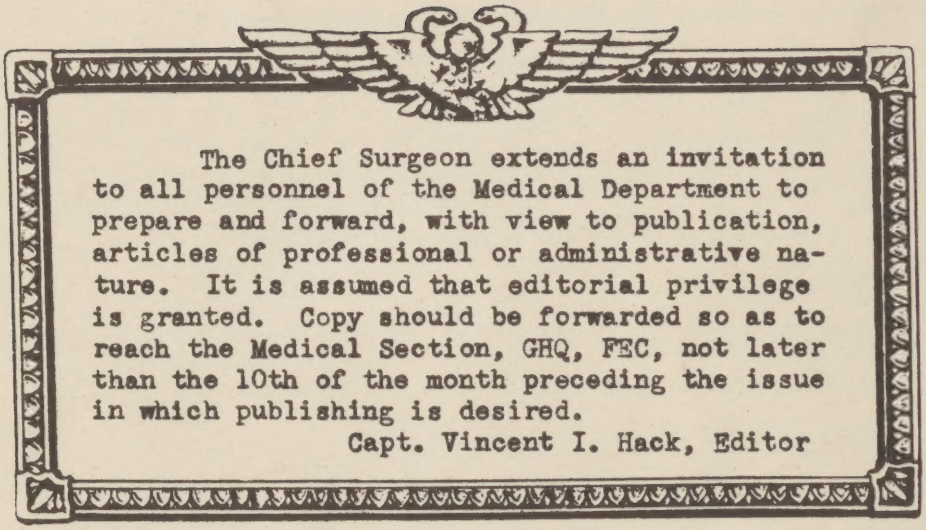

The Chief Surgeon extends an invitation to all personnel of the Medical Department to prepare and forward, with view to publication, articles of professional or administrative nature. It is assumed that editorial privilege is granted. Copy should be forwarded so as to reach the Medical Section, GHQ, FEC, not later than the 10th of the month preceding the issue in which publishing is desired.

Capt. Vincent I. Hack, Editor